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No. 80-1594

In the Supreme Court of the United States

OCTOBER TERM, 1981

UNITED STATES OF AMERICA,
PETITIONER,

v.

ERIKA, INC.,
RESPONDENT.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF CLAIMS

BRIEF FOR THE RESPONDENT

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I

Questions Presented

1. Does the Court of Claims have jurisdiction under 28 U.S.C. § 1491 (1976 & Supp. III 1979) to adjudicate a claim that a Medicare intermediary has violated the Constitution or federal statutes in determining benefits payable under Part B of the Medicare Act, 42 U.S.C. § 1395j *et seq.* (1976 & Supp. III 1979)?

2. When Congress enacted 42 U.S.C. § 1395ff (1976), did it, by implication, partially repeal the Tucker Act, 28 U.S.C. § 1491, to eliminate Court of Claims jurisdiction over constitutional and statutory challenges to Part B Medicare determinations?

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ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF CLAIMS

BRIEF FOR THE RESPONDENT

Statutes Involved

28 U.S.C. § 1491 (1976 & Supp. III 1979):

> The Court of Claims shall have jurisdiction to render judgment upon any claims against the United States founded either upon the Constitution, or any act of Congress, or any regulation of an executive department, or upon any express or implied contract with the United States, or for liquidated or unliquidated damages in cases

> not sounding in tort .... To provide an entire remedy and to complete the relief afforded by the judgment, the court may, as an incident of and collateral to any such judgment, issue orders directing restoration to office or position, placement in appropriate duty or retirement status, and correction of applicable records, and such orders may be issued to any appropriate official of the United States. In any case within its jurisdiction, the court shall have the power to remand appropriate matters to any administrative or executive body or official with such direction as it may deem proper and just ....

42 U.S.C. §§ 405(h), 1395u and 1395ff (1976 & Supp. III 1979) are reproduced at Appendix A-1 *et seq.*

Statement of the Case

The only issue before this Court is whether the Court of Claims had jurisdiction to adjudicate the claim of Erika, Inc.[1] ("Erika") for payments due to Erika from the Government under Part B of the Health Insurance for the Aged and Disabled Act, Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395j *et seq.* (1976 & Supp. III 1979), commonly known as the Medicare Act. The Medicare Act was passed in 1965 as part of the Social Security Act of that year.

The Medicare Program is divided into two parts. Part A is an insurance program covering hospital and related post-hospitalization services, 42 U.S.C. §§ 1395c to 1395i-2 (1976 & Supp. III 1979). Part A is financed by the Federal Hospital Insurance Trust Fund, with funds appropriated by Congress

[1] Erika, Inc. is a wholly owned subsidiary of Bio-Medical Applications Management Company, Inc., which in turn is a wholly owned subsidiary of National Medical Care, Inc., a public corporation. Bio-Medical Applications Management Company, Inc. has approximately 200 other subsidiaries, most of which are wholly owned by it and none of which are less than 95 percent owned by it.

in an amount equal to certain taxes paid by employees, employers and self-employed persons. *See* 42 U.S.C. § 1395i(a) & (h) (1976 & Supp. III 1979), 26 U.S.C. §§ 1401(b), 3101(b) & 3111(b) (Supp. III 1979).

Part B is a voluntary supplemental insurance program, 42 U.S.C. §§ 1395j - 1395w (1976 & Supp. III 1979), generally relating to non-hospital medical care providers such as physicians. *Id.* §§ 1395l, 1395x(s). Persons enrolling in Part B do so voluntarily and pay a monthly premium to participate. *Id.* § 1395r. Their premiums, together with contributions by the United States, are paid into the Federal Supplementary Medical Insurance Trust Fund. *Id.* § 1395t. This trust fund is separate from that established under Part A.

Part B benefits are administered by private insurance carriers, pursuant to contracts entered into between the carriers and the Secretary of Health and Human Services.[2] 42 U.S.C. § 1395u (1976 & Supp. III 1979). The contracts with the carriers require them to determine, using statutory guidelines, reasonable charges for covered medical services provided to the beneficiaries. Eighty per cent of these charges are paid to the beneficiary by the carrier on behalf of the Secretary, or to the provider of the services if the provider has obtained a valid assignment from the beneficiary. *Id.* §§ 1395l & 1395u(b)(3)(B). The statute requires that the contracts between the carriers and the Secretary must provide for "a fair hearing by the carrier" if a request for payment is denied or a dispute arises over the amount of payment for a service, and if the amount in controversy is $100 or more. *Id.* § 1395u(b)(3)(C). There is no express provision in the statute for review by the Secretary or any governmental administrative agency of the carrier's decision as to reasonable charges or as to nonpayment for a particular service.

Coverage under both Parts A and B was extended effective July 1, 1973 to any covered person, regardless of age, who re-

[2] Or by his predecessor, the Secretary of Health, Education and Welfare.

quires kidney maintenance dialysis. 42 U.S.C. § 426-1 (Supp. III 1979) & former § 426(e)(1976). Erika is a New Jersey based major distributor of kidney dialysis equipment and supplies throughout the United States. *Erika, Inc.* v. *United States*, 634 F.2d 580, 583 (Ct. Cl. 1980) (Pet. App. 4a); Pet. App. 84a-85a.[3] Since 1974, as an assignee of its customers/patients, Erika has billed its carrier, The Prudential Insurance Company of America ("Prudential"), for sales of covered products to patients eligible for coverage under Part B. *id.* Under 42 U.S.C. § 1395u(b)(3) (1976 & Supp. III 1979), Prudential's contract with the Secretary required Prudential to determine the "reasonable charges" for those products and to pay Erika 80 per cent of these "reasonable charges."

In administering the Part B payments to Erika, Prudential was required, pursuant to its contract with the Secretary and 42 U.S.C. § 1395u (1976 & Supp. III 1979), to limit its determination of "reasonable charges" in general to be no higher than the "customary charges" by Erika and the "prevailing charges" in the locality. Because Erika's Part B billing to Prudential represented the overwhelming majority of the billings submitted to Prudential for such services, Prudential considered Erika's customary charges to be the prevailing charges in the locality. *Erika, Inc.* v. *United States, supra*, 634 F.2d at 584 (Pet. App. 4a-5a); Pet. App. 55a, 84a-85a.

Since Erika submitted its invoices to Prudential directly, Prudential had available to it all of Erika's actual charges for Part B supplies and services and hence could have derived exact statistical data on Erika's customary charges as well as "prevailing" charges. However, instead of using statistical data derived from actual charges, Prudential took Erika's catalogue prices as of July 1 in any given year and determined that those prices were both the customary charges and the prevailing charge for that calendar year. *See* U.S. Br. at 9.

[3] References to documents reproduced in the Appendix to the Petition for Certiorari are denoted "Pet. App."; in the Appendix to the Brief in Opposition "Opp. App."; in the Appendix hereto "App." References to the Supplemental Petition in the Court of Claims are denoted "Supp. Pet." and to the Brief for the Petitioner "U.S. Br."

It then used those catalogue prices instead of actual statistical data as the "prevailing charge" limit on reasonable charges payable to Erika for the fiscal year commencing on the following July 1. As an example, Prudential used Erika's July 1, 1974 catalogue prices alone as the "reasonable charges" for the year from July 1, 1975 through June 30, 1976. *Id.* Prudential thereby ignored both available later supplements to the catalogues and the prices actually billed by Erika. Prudential never used any available statistical data to determine actual customary or prevailing charges.

Erika, upon discovering the manner in which Prudential had been determining "reasonable charges", objected to the mechanical application of Erika's July 1 catalogue prices. Early in 1976, Erika requested that Prudential adjust the amounts of past and future reimbursements to reflect Erika's actual prices. 634 F.2d at 584 (Pet. App. 6a); Pet. App. 35a-36a, 58a-59a, 78a; Supp. Pet. ¶¶ 30, 46, 66. In particular, Erika claimed, first, that its July 1, 1974 catalogue contained a substantial printing error for one price, which was corrected in a supplement to the catalogue issued shortly thereafter. Supp. Pet. Count I. Prudential nonetheless had used the misprinted price as the limit on reimbursement until February, 1976.[4] Second, with respect to a particular product, heparin, which at the time was subject to rapidly rising prices due to a worldwide shortage of beef, from which it is made, Erika claimed that it was entitled to recognition of those price increases as they took place. Prudential made an adjustment for the price of heparin but only effective prospectively as of months, or years, after the increases took place. Supp. Pet. Count II. Third, Erika objected to the fact that while the July 1 prices for many products were often increased after the cata-

[4] Prudential's refusal to correct its prior use of the 1974 printing error to determine reasonable charges was the subject of Count I of Erika's Petition in the Court of Claims. That Count was settled and it is not here in issue. See U.S. Br. at 10 n.11.

logue was issued, Prudential ignored all catalogue supplements effecting those adjustments. It also ignored actual sales data in favor of using the single July 1 catalogue prices. Supp. Pet. Count III. Moreover, Erika claimed that Prudential's use of Erika's price as automatically establishing both the "customary" and "prevailing" charge was anomalous due to an accident of geography, logically circular, unreasonable and contrary to the Medicare statute. Erika therefore challenged Prudential's practices as being, *inter alia*, arbitrary and in violation of the Medicare statute and the Constitution.

Prudential declined to change its practices and to make the requested adjustments and changes. Retroactive adjustment was denied altogether on the basis of certain directives which Prudential believed prohibited it from granting *any* retroactive adjustment. Erika then requested a "fair hearing" from Prudential's hearing officer. *See* 634 F.2d at 584 (Pet. App. 6a); Pet. App. 34a-88a. After receiving adverse decisions from Prudential's hearing officer, no further administrative appeal being available, Erika in July 1977 brought the subject action against the United States in the Court of Claims.

Erika's petition sought a money judgment in the Court of Claims to correct Prudential's refusal to pay Erika its reasonable charges computed pursuant to the Medicare statute and the Constitution. Erika claimed, and the Court of Claims, sitting *en banc* at the request of the United States, unanimously held, on cross motions for summary judgment on the issue of liability:

(1) that Prudential's method of setting the level of "reasonable charges" for Erika was directly in violation of the Medicare statute, 634 F.2d at 588-89 (Pet. App. 15a-19a); and

(2) that with respect to the determination that Erika was entitled to prospective but not retroactive relief on the charges for heparin, the directive prohibiting retroactive relief on which Prudential had specifically relied was acknowledged to be obsolete and not to cover the years in question. 634 F.2d at 590-91 (Pet. App. 6a-7a).[5]

[5] The above are the only claims as to which the Court of Claims granted relief. Erika asserted other claims, including claims that Prudential's

Prudential had thus engaged in practices directly violative of federal law (and its contract with the Government) in its treatment of Erika's Part B claims. Prudential's statutory (and contractual) violation was so substantial and so obvious that it warranted unanimous summary judgment on liability by the full bench of the Court of Claims. In his concurring opinion Judge Nichols was moved to describe Prudential's actions as "virtual spoliation." Pet. App. 26a.[6]

With respect to the jurisdictional issue, the Court of Claims unanimously held that it had jurisdiction to adjudicate Erika's claims of statutory and constitutional violations in the determination of Part B benefits. Consistent with the procedural posture of the case (the issue of damages had not been addressed in the cross motions for summary judgment on liability), the Court of Claims remanded to Prudential for determination of the amount of damages. In doing so, it was careful

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actions violated the "Just Compensation" Clause of the Fifth Amendment to the Constitution. The United States describes that constitutional claim as a claim under the Due Process Clause, U.S. Br. at 44 n.39, *but see*, U.S. Br. at 11 n.13, and asserts that while the Court of Claims would have jurisdiction over a "Just Compensation" claim, it did not have jurisdiction over a "Due Process" claim. *Id.* Erika in fact pleaded both Just Compensation and Due Process Clause claims. Supp. Pet. ¶ 71(c) ("Those actions . . . deprive the Plaintiff of property without due process of law, and take Plaintiff's property without just compensation, in violation of the Fifth Amendment to the United States Constitution.") While the Court of Claims found the "due process" and "equal protection" claims insubstantial. 634 F.2d at 591 (Pet. App. 22a), the majority appears not to have addressed the "just compensation" claim. *Id.* Judge Nichols in his concurring opinion found the Fifth Amendment taking claim, however, to be at least colorable, and was troubled by the short shrift the majority gave it. 634 F.2d at 593-94 (Pet. App. 27a-28a).

[6] During the pendency of a motion for rehearing filed by the Government, which related to a portion of the Medicare Carriers Manual not directly in issue in this case, Erika's counsel was informed by Prudential that if the motion for rehearing were allowed Prudential would use that determination to avoid correcting the statutory violation found by the Court of Claims. (Opp. App. A-12—A-13). Erika brought this to the attention of the Court of Claims which inserted a final paragraph into its Order on rehearing to prevent Prudential from doing so. Pet. App. 32a-33a. The Carrier's attempted action in this regard was consistent with the type of behavior to which Judge Nichols referred.

not to encroach on areas left to Prudential's discretion and expertise in setting reasonable charge levels. 634 F.2d at 589, 591 (Pet. App. 17a-18a, 21a).

On March 20, 1981, the United States filed a Petition for Writ of Certiorari for review of the decision of the Court of Claims, but limited solely to the issue of the Court of Claims' jurisdiction. The petition was granted on May 18, 1981. No petition or cross-petition was filed with respect to the merits of the Court of Claims' decision.

Summary of Argument

The Court of Claims' jurisdiction over Medicare Part B claims arises under the Tucker Act, 28 U.S.C. § 1491 (1976 & Supp. III 1979).

The Tucker Act constitutes a general grant of jurisdiction in the Court of Claims over non-tort claims for money judgments against the United States. Jurisdiction in the Court of Claims over Medicare Part B claims therefore exists under the Tucker Act if there is a substantive right to money damages against the United States under Part B and if Congress has not acted partially to repeal the Tucker Act or to withdraw the substantive right.

A substantive right to money damages against the United States under Part B arises both as a matter of contract and because the Medicare Statute, fairly read, mandates such a substantive right to recover damages. With respect to contract rights, Part B is a voluntary insurance program into which beneficiaries pay premiums. Such a program creates an implied-in-fact contract pursuant to which the beneficiaries are entitled to judicial enforcement of their rights against the United States. Moreover, Prudential, as agent for the Secretary, entered into an implied-in-fact contract with Erika requiring payment to Erika, in amounts to be determined consistent with the statute, for goods and services provided by Erika and accepted by the Part B beneficiaries and Prudential.

Finally, even if there were no implied-in-fact contracts, Erika could enforce, as a third party beneficiary, the Secretary's express contract with Prudential. By entering into such contracts, the United States has waived its sovereign immunity and created a substantive right to recover damages in the Court of Claims.

Even in the absence of contractual rights, Part B of the Medicare statute creates a system of medical insurance which mandates a right of the premium paying beneficiaries to enforce judicially their rights to receive payment in accordance with the statute. Erika, as assignee, stands in the shoes of those beneficiaries.

Nothing Congress has done has withdrawn that substantive right of action under Part B or repealed the Court of Claims' Tucker Act jurisdiction over those substantive claims. In particular, contrary to the argument of the United States, in enacting 42 U.S.C. §§ 1395ff & 405(h) (1976), Congress did neither. Section 1395ff provides for judicial review in the district courts after a governmental administrative hearing in controversies in which the Secretary is to make the initial decision. It is silent as to judicial or administrative review of reimbursement decisions to be made by carriers under Part B, not because Congress wished to foreclose premium paying beneficiaries from judicially enforcing their rights to benefits computed and paid pursuant to Part B, but rather at most because Congress considered that governmental administrative review and full judicial review in the district courts on the governmental administrative record was not necessary or appropriate for carriers' decisions. However, Congress left the Court of Claims as the one court with jurisdiction to render a money judgment for benefits in the event the benefits were not paid or computed consistent with the statute and Constitution.

Similarly 42 U.S.C. § 405(h) at most precludes any form of judicial review of decisions made *by the Secretary* other than the statutory judicial review provided for those decisions in

§§ 1395ff & 405(g). It is silent as to judicial review of decisions by private carriers. The United States' contention that a decision of a carrier is a decision of the Secretary for purposes of this statute is contrary to the plain meaning of the statute and inconsistent with the statutory scheme.

There being no unequivocal withdrawal of jurisdiction to adjudicate statutory and constitutional challenges to Part B benefit denials, the Court of Claims had jurisdiction over this matter under the Tucker Act. Its decision should be affirmed.

Moreover, the United States' interpretation of the Medicare statute to deny Court of Claims jurisdiction over Part B benefit claims raises serious constitutional issues. It means of necessity that no judicial or even governmental forum would be available to review unlawful or unconstitutional actions taken by private insurers as agents of the United States. This conclusion would place in serious doubt the constitutionality of the entire Part B private carrier payment mechanism. Such a dilemma need not be faced, however, since the Medicare statute can and should be interpreted to continue to allow the Court of Claims to exercise its limited jurisdiction over Part B claims.

Argument

I. Introduction: The Court of Claims' Analysis of its Jurisdiction Over Medicare Claims

The Court of Claims, in analyzing the extent of its own jurisdiction under the Medicare Act, has adopted a consistent and reasonable approach. It first has recognized the general rule that under the Tucker Act, 28 U.S.C. § 1491 (1976 & Supp. III 1979), it has a broad grant of jurisdiction over non-tort claims for money damages against the United States. *Erika, Inc.* v. *United States, supra*, 634 F.2d at 585. That broad grant of jurisdiction is explicit:

> "The Court of Claims shall have jurisdiction to render judgment upon any claim against the United States founded either upon the Constitution, or any Act of

> Congress, or any regulation of an executive department, or upon any express or implied contract with the United States, or for liquidated or unliquidated damages in cases not sounding in tort ...."

28 U.S.C. § 1491.

It then has determined that under the Medicare Act there is generally a substantive right of action against the United States for benefits either because of the United States' entering into contracts for payment of such benefits or because the Medicare Act, fairly read, mandates appropriate payment. *Whitecliff, Inc.* v. *United States*, 210 Ct. Cl. 53, 58, 536 F.2d 347, 351 (1976), *cert. denied*, 430 U.S. 969 (1977); *Overlook Nursing Home, Inc.* v. *United States*, 214 Ct. Cl. 60, 556 F.2d 500 (1977).

Having recognized that general rule regarding its jurisdiction over Medicare Act claims, the Court of Claims has analyzed whether any action by Congress either has precluded it from exercising such jurisdiction over the particular types of claims asserted in a given case or has withdrawn the substantive right to damages for a particular class of claims. *Id.*; *Erika, Inc.* v. *United States*, *supra*, 634 F.2d at 585-88 (Pet. App. 7a-15a).

In the instant case each element of the Court of Claims' analysis compelled it to exercise jurisdiction: it has jurisdiction over non-tort claims for money damages against the United States and a general substantive right to such damages under Part B of the Medicare Act exists. Finally, nothing Congress has done has substantively eliminated Erika's rights to damages or repealed the Court of Claims' jurisdiction over the type of claim which Erika asserted. Therefore jurisdiction existed.

II. The Court of Claims Has Jurisdiction Over Claims for Benefits Under the Medicare Act

A. *Erika's Claim is a Non-Tort Claim Against the United States for Money Damages*

Under the Tucker Act, 28 U.S.C. § 1491 (1976 & Supp. III 1979), the Court of Claims has jurisdiction to render a money judgment against the United States on claims founded on the Constitution, federal statutes or regulations, on contracts, or on other non-tort causes of action.

Erika's claim was for money damages, from the United States, under an Act of Congress or upon an express or implied contract, or otherwise for damages in a case not sounding in tort. As the Court of Claims recognized, "[o]n its face, [Erika's] petition states a claim within [Court of Claims] jurisdiction under the Tucker Act." *Erika, Inc.* v. *United States, supra*, 634 F.2d at 585 (Pet. App. 7a).

Despite the surficial applicability of this broad grant of jurisdiction, the United States argues that Congress, in Part B of the Medicare program, implicitly repealed the Tucker Act, in part, so as to preclude the Court of Claims from exercising jurisdiction to enter a judgment for money damages for any claims under Part B of the Medicare Act, including Erika's claims. U.S. Br. at 20. In an apparent rephrasing of this assertion, the United States argues as well that under Part B of the Medicare program Congress has not granted beneficiaries and their assignees any judicially enforceable right to receive benefits computed in accordance with the statute. *Id.* at 38-42.

Looking first to the general rule, it is clear from the language of the Tucker Act that absent some affirmative action by Congress carving out an exception to that Act, the

Court of Claims would have jurisdiction to enter a money judgment on any valid claim under Part B. Even though a carrier is the entity which in the ordinary course would make payments to Erika, the United States is the source of the funds for the payments and the real party in interest in disputes over Part B benefits. 42 C.F.R. § 421.5(b) (1980); *Kuenstler* v. *Occidental Life Ins. Co.*, 292 F. Supp. 532, 535 (C.D. Cal. 1968). The United States acknowledges this. U.S. Br. at 27 n.24. Erika's claim is against the United States.

The Tucker Act, however, is only jurisdictional. *United States* v. *Testan*, 424 U.S. 392, 398 (1976). Any substantive right to money damages from the United States must be derived from contracts, statutes or regulations other than the Tucker Act itself. *Id.* Erika has such a substantive right.

B. *Part B Beneficiaries and Their Assignees Have a Substantive Right to Recover Money Damages From the United States*

The United States is deemed to have waived its sovereign immunity, and thus is subject to suit in the Court of Claims, when the claimant is owed money from the United States upon a contract, is owed money wrongfully retained by the United States, or when "any federal statute 'can fairly be interpreted as mandating compensation by the Federal Government for the damage sustained.' " *United States* v. *Testan*, *supra*, 424 U.S. at 400, quoting *Eastport S.S. Corp.* v. *United States*, 178 Ct. Cl. 599, 607, 372 F.2d 1002, 1009 (1967); *Mosca* v. *United States*, 189 Ct. Cl. 283, 290, 417 F.2d 1382, 1386 (1969), *cert. denied*, 399 U.S. 911 (1970).

With respect to Erika's Part B claim, the United States has waived its sovereign immunity and created a substantive right to money damages both as a contractual and statutory matter. The United States contracted both with the part B bene-

ficiaries and with Prudential to pay the beneficiaries and their assignees in conformity with the statute. *See* 42 U.S.C. § 1395u (1976 & Supp. III 1979). Having sold and delivered goods and services to beneficiaries under Part B, and received assignments of those beneficiaries' claims for payment from Prudential and the United States, Erika has a contractual claim for benefits under Part B. *See Fox* v. *Harris*, 488 F. Supp. 488, 495 (D.D.C. 1980).

As a statutory matter, moreover, the Medicare legislation, fairly read, mandates appropriate payment to providers. *Whitecliff, Inc.* v. *United States*, 210 Ct. Cl. 53, 58, 536 F.2d 347, 351 (1976), *cert. denied*, 430 U.S. 969 (1977).

1. *Part B Beneficiaries and Their Assignees Have a Contractual Right to Payment of Benefits In Accordance With the Medicare Statute.*

The United States, both by enacting Part B as a voluntary program paid for in part by beneficiaries' premiums, and by authorizing and entering into contracts with carriers to supervise and process payments to Part B beneficiaries and their provider assignees, has created a contractual right to payment in accordance with the Medicare statute which is enforceable by the beneficiaries and their assignees.

a. *Erika Had An Implied-in-Fact Contract With the United States For Payment Pursuant to Part B of the Medicare Act.*

Implied-in-fact contracts with the United States have been a basis for the exercise of Court of Claims jurisdiction for many years. *E.g., Baltimore & O.R.R.* v. *United States*, 261 U.S. 592 (1923); *Scanwell Laboratories* v. *Shaffer*, 424 F.2d 859 (D.C. Cir. 1970); *Heyer Prods. Co.* v. *United States*, 135 Ct. Cl. 63, 140 F. Supp. 409 (1956).

A contract implied in fact is an agreement "founded upon a meeting of minds, which, although not embodied in an express contract, is inferred, as a fact, from conduct of the parties showing, in the light of the surrounding circumstances, their tacit understanding." *Baltimore & O.R.R.* v. *United States*, 261 U.S. 592, 597 (1923).

The relationship between Part B beneficiaries and the United States creates an implied-in-fact contract. The United States has offered to provide a supplemental insurance program which would entitle the program enrollees to certain medical expense reimbursement benefits. The beneficiaries accept that offer by voluntarily enrolling in the program. 42 U.S.C. § 1395p (1976). They pay "premiums" for their "medical insurance" under Part B. 42 U.S.C. § 1395r (1976 & Supp. III 1979). These premiums are paid into a trust fund separate and distinct from the fund established under Part A. If the beneficiary defaults in the payment of premiums, his or her coverage is terminated. 42 U.S.C. § 1395q(b)(2) (1976).

The analogy to a private insurance contract is too close to be ignored. The beneficiaries have accepted an offer, have parted with consideration, and there is a meeting of the minds. The beneficiaries are entitled to that for which they have paid. The benefits are described in terms of "entitlement", 42 U.S.C. § 1395k (1976 & Supp. III 1979), not of contingency or condition. It is unlikely that even the United States will argue that it was anyone's understanding that the beneficiaries pay their premiums in return for a promise which could be broken with complete impunity upon the whim, caprice or mistake of a private, profit-making insurer acting as a carrier.

Moreover, several elements in the relationship between Erika and Prudential point to a distinct contract implied in fact between them. Erika provided goods and services under an understanding that it would be paid for them in a manner and in an amount consistent both with the Medicare statute and Prudential's contract with the Secretary. There was a reasonable expectation that Prudential would authorize and

make payment for the goods and services. Assent to this understanding was expressed in the continued acceptance and payment (albeit partial) by Prudential for Erika's services. Consideration passed to the United States, since goods were sold and delivered to the beneficiaries of its statutory program, and since Erika detrimentally relied on the United States' promise to pay the "reasonable charges" for such services. Such consideration is a "fundamental" requirement for recovery under the Tucker Act, *Somali Dev. Bank* v. *United States*, 205 Ct. Cl. 741, 750, 508 F.2d 817, 822 (1974). Moreover, the value of the services provided to the government could either be used as support for a suit for the value of the services in quantum meruit, *Cities Serv. Gas Co.* v. *United States*, 205 Ct. Cl. 16, 500 F.2d 448 (1974), or for an action based upon a construction of the implied contractual term "reasonable charges" as including the statutory requirements for the computation of those charges. In *Cities Serv. Gas Co.* v. *United States*, *id.*, for example, the plaintiff had sold and delivered gas to the United States under an implied (but not express) contract. The Court of Claims exercised jurisdiction over the claim and held that the plaintiff could recover the value of all such gas on a quantum meruit basis in the absence of any price term in the implied-in-fact contract. *Id.* at 33, 500 F.2d at 457.

The United States, in entering into a contract with Prudential, has already waived its sovereign immunity as to claims under that contract. That contract, moreover, required Prudential to enter into a relationship with Erika to pay money to Erika for goods sold and delivered or services rendered. Erika's goods were not delivered gratuitously. The amounts of Prudential's payments for such goods and services were to be determined pursuant to statutory guidelines. All parties intended those payments to be made. Since Erika furnished goods and services to the beneficiaries of the Part B program, and Prudential, in effect, accepted or confirmed the ac-

ceptance of those goods and services, a contract for payment by Prudential to Erika for those goods and services must be implied in fact.

Both the United States' contract with Part B beneficiaries and Prudential's contract with Erika required Prudential to compute the amount of the payments consistent with its contractual and statutory authority and actually to make those payments. Because Prudential did not do so, Erika had a right to damages for the breach of those implied-in-fact contracts. That right was enforceable against Prudential's principal, the United States.

b. *Erika Could Sue As An Intended Third Party Beneficiary to Prudential's Contract With the United States.*

Even if no contract between Erika and Prudential or the United States could be implied in fact, Erika has the right as a third party beneficiary to enforce the contract between the Secretary and Prudential.

The Court of Claims has jurisdiction over third party beneficiary claims based upon a government contract. E.g., *Hebah* v. *United States*, 192 Ct. Cl. 785, 792, 428 F.2d 1334, 1339 (1970) ("It is settled, moreover, that an intended third-party beneficiary of a government contract may sue under § 1491"); *accord*, *Maneely* v. *United States*, 68 Ct. Cl. 623, 629 (1929); *Deltec Corp.* v. *United States*, 164 Ct. Cl. 432, 328 F.2d 1004 (1964).

As this Court has recognized, when a contract is plainly for the benefit of a non-contracting party, that party has the right to enforce it. *Crumady* v. *The Joachim Hendrik Fisser*, 358 U.S. 423, 428 (1959), *citing with approval*, *Restatement, Law of Contracts*, § 133. In the classification of the *Restatement (Second) of Contracts*, Erika is an "intended" beneficiary. *Restatement (Second), of Contracts* § 133 (1973). "... [A] beneficiary of a promise is an intended beneficiary if recognition of a right to performance in the beneficiary is appropriate

to effectuate the intention of the parties and the circumstances indicate that the promisee intends to give the beneficiary the benefit of a promised performance." *Id.*

The intent of the Secretary's contract with Prudential was clearly to benefit Medicare beneficiaries and their suppliers. The statutory purpose of the Medicare program is to convey a benefit to aged or disabled beneficiaries. The provisions for establishing reasonable reimbursement to those suppliers who undertake to provide goods and services to covered persons are manifestly for the benefit of both the covered person and the supplier.

The Secretary's purposes in contracting with Prudential were expressly consistent with and in furtherance of the purposes of the Medicare statute. Performance of Prudential's contractual promise to provide reimbursement "benefits" to individual recipients or their assignees was intended by both promisor and promisee. Prudential's performance in making payments was to be rendered directly to beneficiaries and assignees, not to the United States.

Moreover, individual beneficiaries and/or their assignees had to participate, cooperatively, in the payment process for Prudential's performance to occur. The beneficiaries and their assignees were sufficiently defined and described in the contract so as to be identifiable. Prudential could reasonably foresee that its failure to perform would cause harm to beneficiaries and their assignees. In addition, Prudential, to the knowledge of the promisee, viewed reimbursement of beneficiaries in accordance with the statute as its obligation in exchange for the consideration promised to Prudential.

Erika could even be classed as a creditor beneficiary. The Secretary has a statutory obligation to reimburse beneficiaries and their assignees for all covered "fair and reasonable" charges. In order to carry out this obligation, the Secretary "is authorized to enter into contracts with carriers" such as Prudential. 42 U.S.C. § 1395u(a) (1976). Prudential, in con-

sideration of funds received from the United States, promised to "make determinations of the rates and amounts of payments required . . . to be made to providers of services and other persons on a reasonable cost or reasonable charge basis (as may be applicable)", *id.* § 1395u(a)(1)(A), and to "receive, disburse and account for funds in making such payments." 42 U.S.C. § 1395u(a)(1)(B). Erika, having provided goods and services in reliance on the statute and on Prudential's obligation to comply with its contract in making payments to Erika, is a creditor beneficiary of this contract. It therefore may sue for its enforcement.

The United States contracted with Prudential to have Prudential take certain actions with respect to setting the levels of payment and making payment to Medicare beneficiaries. Entry into that contract constituted a waiver of sovereign immunity with respect to enforcement of its provisions.

That waiver of sovereign immunity is broad enough to cover any judicially cognizable claim on the contract, whether it is a claim by Prudential, by a third-party beneficiary or by a party to a new contract entered into by Prudential as agent for the United States. In the absence of express limitations on that waiver, the Court of Claims has jurisdiction, therefore, to adjudicate claims for reimbursement under Part B of Medicare.

2. *The Medicare Legislation, Fairly Read, Mandates Appropriate Payment to Providers*

Even apart from the waiver of sovereign immunity implicit in the United States' contracting with Part B enrollees, with Prudential and with Erika, the Medicare Act itself mandates a judicially enforceable substantive right to payment. The Court of Claims has consistently recognized this principle, *e.g.*, *St. Elizabeth Hosp.* v. *United States*, 214 Ct. Cl. 322, 326-27, 558 F.2d 8, 11 (1977); *Whitecliff, Inc.* v. *United States*, *supra*, at 58, 536 F.2d at 351; *Alabama Hosp. Assn.* v. *United States*, No. 465-79C (Ct. Cl. June 17, 1981).

The Medicare statute on its face requires payment to beneficiaries and providers. 42 U.S.C. § 1395u (1976 & Supp. III 1979). Its description of Part B benefits is in terms of "entitlement", *id.* § 1395k, language which is mandatory, not permissive. *See Selman* v. *United States*, 204 Ct. Cl. 675, 498 F.2d 1354 (1974). If beneficiaries and suppliers are "entitled" to payments, as a general proposition they must be entitled to compel payment of benefits wrongfully withheld. *See Marbury* v. *Madison*, 5 U.S. (1 Cranch.) 135, 162 (1803). The beneficiaries, never knowing whether they would be personally liable for 100 per cent or 20 percent of the costs of their kidney dialysis or other medical treatment, would have neither insurance nor security under this health insurance part of the Social Security program. On the other hand, if suppliers were not so entitled but were dependent solely on an unenforceable commitment that they might be paid under Medicare, their willingness to cooperate with the program, to ship on less than C.O.D. terms and indeed to enter into the market would be jeopardized, all to the detriment of the would-be Medicare beneficiaries. The ability to enforce a right to payment must be implicit in a fair reading of the Medicare statute.

> We cannot believe that Congress intended in 1965 that Medicare providers would be "entitled" to whatever reimbursement the Secretary (or fiscal intermediary) granted, be it high or low, fairly or unfairly set. The Medicare Act does not, of course, show any legislative intent to aid providers of care for their own sakes . . . The Congressional concern was rather for the Act's beneficiaries. *Id.* Yet making provider reimbursements unreviewable would doubtless chill the provision of care to beneficiaries, or perhaps worse, would encourage providers to cheapen the care given to Medicare patients. More unscrupulous providers might choose to offset insufficient Medicare reimbursements by charging higher fees to non-Medicare patients. This would contravene one objective of the Act,

> which is that "the costs of services of [sic] individuals covered by the program will not be borne by individuals not covered ..." S.Rep. No. 89-404, 89th Cong., 1st Sess., *as reprinted in* 1 [1965] *U.S. Code Cong. & Admin. News.* pp. 1943, 1976.

Chelsea Community Hosp. v. *Michigan Blue Cross Ass'n*, 630 F.2d 1131, 1136 (6th Cir. 1980) (citations omitted).

For the government to accept the funds of older or disabled Americans in return for a promised benefit of crucial importance to them, and yet to have their right to that benefit totally subject to the errors or even whims not only of governmental agencies, but also of private, profit-making carriers, with no recourse to judicial review, is so unacceptable that the government's argument must fail. The United States can reasonably, albeit incorrectly, assert that Congress has circumscribed beneficiaries' rights to judicial review, but for it to suggest that Part B of the Medicare Act, fairly read, does not give its beneficiaries enforceable rights to benefits, argues too much. A right to judicial enforcement of a Part B beneficiary's rights must be mandated by the Medicare statute.

As a corollary, judicial enforcement of a right to payment *in accordance with the statutory scheme* must be implicit in the statute. Indeed, payment could not lawfully be mandated except in accordance with the statute.

The Court of Claims has therefore repeatedly held that 28 U.S.C. § 1491 (1976 & Supp. III 1979) confers jurisdiction upon it to resolve claims for Medicare reimbursement, including claims by providers for reimbursement, unless specific legislation provides that judicial review is available exclusively elsewhere or that jurisdiction in the Court of Claims is clearly precluded. *Appalachian Regional Hosps., Inc.* v. *United States*, 217 Ct. Cl. 1, 8, 576 F.2d 858, 861-862 (1978), and cases cited. Thus, unless Congress has acted expressly to preclude actions in the Court of Claims relating to Part B benefit determinations, such actions are within the Court of Claims' jurisdiction.

The Government's jurisdictional argument in essence is that Congress has carved out such an exception to that general grant of jurisdiction and waiver of sovereign immunity. None of the Congressional actions referred to by the Government, however, either deprived the Court of Claims of its jurisdiction under the Tucker Act to decide this case or withdrew the waiver of sovereign immunity inherent in the Medicare contracts and statute.

III. Congress Did Not Preclude Review of Part B Benefit Determinations in the Court of Claims

The United States' contention that Congress deprived the Court of Claims of jurisdiction in this matter rests on two arguments:

1. That 42 U.S.C. § 1395ff (1976) provides for a particular form of administrative and judicial review of decisions as to the amount of, and eligibility for, certain Part A benefits and as to eligibility for Part B benefits, but is silent as to judicial review of Part B benefit determinations. The United States argues, therefore, that Congress thereby intended to preclude all judicial scrutiny of Part B benefit determinations. The United States also quotes legislative history of the Medicare Act and amendments suggesting that the decision not to include statutory language specifically permitting judicial review of a determination of the amount of Part B benefits was deliberate.

2. That Section 205(h) of the Social Security Act, 42 U.S.C. § 405(h) (1976), applicable through 42 U.S.C. § 1395ii (1976), precludes all judicial review of the carrier's determinations under Part B.

The Government's burden on this issue is a very heavy one: it must provide "clear and convincing" evidence of congressional intent before this Court will construe a statute to restrict

access to judicial review. *Johnson* v. *Robison*, 415 U.S. 361, 373-74 (1974).[7] "[J]udicial review of a final agency action by an aggrieved person will not be cut off unless there is persuasive reason to believe that such was the purpose of Congress." *Abbott Laboratories* v. *Gardner*, 387 U.S. 136, 140 (1967) and cased cited.

A. *42 U.S.C. § 1395ff Does Not Deprive the Court of Claims of Jurisdiction in This Matter*

The United States contends that 42 U.S.C. § 1395ff (1976), because it provides for administrative and judicial review of certain Medicare disputes but is silent as to Part B benefit determinations, implicitly deprives the Court of Claims of jurisdiction over this matter. However, neither the statutory language nor the legislative history compels that conclusion.

42 U.S.C. § 1395ff (a) (1976) provides, in pertinent part, that the Secretary will make a determination as to:

> (1) whether an individual is eligible under Part A of Medicare,
>
> (2) whether he or she is eligible under Part B of Medicare, and
>
> (3) the amount of benefits under Part A.

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[7] The United States attempts to avoid this issue by arguing that *Johnson* v. *Robison* dealt only with preclusion of judicial scrutiny of constitutional issues, and that the majority below found Erika's constitutional claims insubstantial. The issue cannot be so easily avoided. The United States' claim that the Medicare statute deprived the Court of Claims of jurisdiction to review carriers' decisions would apply regardless of the substantive basis for the provider's attack on the carrier's decision, whether that basis is statutory, contractual, equitable or constitutional. There is no principled basis for creating a constitutional issue exception to the argument, and the United States proffers none. Indeed, in *Weinberger* v. *Salfi*, 422 U.S. 749 (1975), this Court made it clear that if review of a Social Security Act claim were statutorily precluded, the presence of a constitutional claim to benefits under the Act would not overcome the statutory preclusion of review. *Id.* at 760-61.

Moreover, there is a presumption in favor of judicial review of any agency decision, *Abbott Laboratories* v. *Gardner*, 387 U.S. 136, 140 (1967), and regardless of how the government's burden is characterized, it is a heavy one.

Under § 1395ff(b), an individual dissatisfied with the determination by the Secretary on any of these issues is entitled to an administrative hearing by the Secretary and to judicial review of the Secretary's final decision. That section also provides that no such *administrative* hearing as to the amount of Part A benefits is available if the amount in controversy is less than $100. Likewise, the statute expressly states that no *judicial* review of the Secretary's determination as to the amount of Part A benefits is available if the amount in controversy is less than $1,000.

Section 1395ff is silent regarding determinations as to the amount of Part B benefits. The Government argues that that silence implicitly evidenced a preclusion of judicial review of Part B determinations.

However, the most readily apparent reason why § 1395ff, which relates to decisions required to be made by the Secretary, is silent as to judicial review of Part B benefit determinations, is that such determinations are to be made by carriers, rather than by the Secretary. *See* 42 U.S.C. § 1395u (1976 & Supp. III 1979); Report of the Senate Committee on Finance, S. Rep. No. 404, Part I, 89th Cong., 1st Sess. 54-55, *reprinted in* [1965] U.S. Code Cong. & Ad. News 1943, 1995. It is under a different section of the statute that those carriers are required, by statute and contract, to have their own determination and private administrative review proceedings completely separate from the decisions by the Secretary and governmental administrative hearings provided for in § 1395ff. 42 U.S.C § 1395u(b)(3)(C) (1976). The carrier is required to:

> establish and maintain procedures pursuant to which an individual enrolled under this part will be granted an opportunity for a fair hearing by the carrier, in any case where the amount in controversy is $100 or more, when requests for payment under this part with respect to ser-

> vices furnished him are denied or are not acted upon with reasonable promptness or when the amount of such payment is in controversy . . . .

(*id.*)

The administrative hearing provisions of § 1395ff, which provide for hearings by the Secretary on decisions to be made by the Secretary, are silent as to administrative hearings by the Secretary on matters in which carriers are required to make the decisions and to provide the hearings themselves under § 1395u(b)(3)(C). The absence of a specific authorization under § 1395ff for administrative review by the Secretary and judicial review thereafter of Secretarial decisions regarding the amount of Part B benefits is thus merely consistent with the fact that there are to be no decisions by the Secretary on those issues. Carriers, rather than the Secretary, are to make those particular determinations, and the hearings to be conducted by the carriers are provided for in § 1395u, not § 1395ff.

Moreover, while in § 1395ff Congress *expressly* precluded judicial review of certain classes of disputes, it was silent as to judicial review of Part B benefit determinations. Silence in § 1395ff on that issue cannot be taken to be the equivalent of Congress' deliberate affirmative preclusion of judicial review of other classes of cases in the same section.

The Government argues, however, that in the legislative history of § 1395ff, the Senate Committee on Finance made the following parenthetical comment to the description of the requirements of hearings by the Secretary contained in § 1395ff:

> . . . (Under the supplementary plan, carriers, not the Secretary, would review beneficiary complaints regarding the amount of benefits, and the bill does not provide for judicial review of a determination concerning the amount of benefits under Part B where claims will probably be for substantially smaller amounts than under Part A.) . . . .

Report of the Senate Committee on Finance, S. Rep. No. 404, art I, 89th Cong., 1st Sess. 54-55, *reprinted in* [1965] U.S. Code Cong. & Ad. News 1943, 1995.

That statement, however, is far from the unambiguous evidence of intent to withdraw Court of Claims' jurisdiction that the Government claims. Administrative remedies under Part B were in fact provided in another section of Title 42 (§ 1395u). At most, the legislative history quoted above indicates that the bill *was deliberately silent* as to judicial review of Part B determinations of the amount of benefits, not that Congress intended that all judicial scrutiny of Part B determinations be prohibited. In view of the fact that Congress was delegating governmental powers to private parties, it is more reasonable to interpret the silence of the statute and the legislative history to mean that while judicial review was not to be augmented by the full review procedures described for Part A determinations, it was still to be available to the extent of the courts' existing jurisdiction. Congress, in the legislative history of § 1395ff, to the extent it dealt at all with administrative decisions under § 1395u, thus merely refused to specify a particular manner in which the carriers' decisions were judicially reviewable. It thereby left the scope of such review to the courts' existing jurisdiction.

The Court of Claims considered this legislative history and read it as precluding ordinary judicial review of the *amount* of a particular benefit determination, not as precluding all judicial consideration of constitutional and statutory challenges to administrative actions which might have an effect on the benefit determinations. *Erika, Inc.* v. *United States, supra*, 634 F.2d at 587-88 (Pet. App. 14a). Such a reading was entirely consistent with the Court of Claims' rulings in *Goldstein* v. *United States*, 201 Ct. Cl. 868, *cert. denied*, 414 U.S. 974 (1973), *Appalachian Regional Hosps., Inc.* v. *United States, supra* at 8, 576 F.2d at 861-62, and *Whitecliff, Inc.* v. *United States, supra* at 57-58, 536 F.2d at 350-51, restricting its jurisdiction in such cases to review of statutory and constitutional claims.

Indeed, the position of the Court of Claims is in complete harmony with the legislative framework. In § 1395ff, Congress was specifying a very particular type of remedy for review of decisions to be made by the Secretary. It provided for a formal hearing analogous to the type of hearing provided under the Administrative Procedures Act, 5 U.S.C. §§ 551 *et seq.* (1976 & Supp. III 1979) (assuming the jurisdictional amount was satisfied) and thereafter for full judicial review in the district courts pursuant to 42 U.S.C. § 405(g) (1976). 42 U.S.C. § 1395ff(b)(1) (1976). Indeed § 405(g) permits judicial review in the district court in the plaintiff's own district, a right of considerable practical importance. The scope of review is on a "substantial evidence" basis and the reviewing court is given broad remedial powers.

Those remedies, at least in that form, are not available for Part B benefit determinations. There is no governmental administrative hearing and no decision by the Secretary. Review in the district courts is apparently precluded (*see* discussion at 32-33 *infra*). The broad remedial powers of a district court, and its ability to review the full breadth of administrative decisions on the record, are denied Part B beneficiaries.

The residuary jurisdiction of the Court of Claims, limited to granting money judgments, or the equivalent in a remand order, and restricted solely to determining whether the statute and Constitution have been complied with, constitutes something far less than judicial review of an administrative decision in any customary manner. Such relief is only a judicial mechanism to require the carrier and the United States to pay the beneficiary that to which it is clearly entitled by statute, contract and the Constitution.

To say that because Congress chose not to give Part B beneficiaries as broad rights as it gave Part A beneficiaries, it therefore chose to deprive Part B beneficiaries of all rights to judicial scrutiny of adverse Part B benefit determinations, is not logical. Congress could certainly have expressed an intent to restrict full "judicial review" similar to that provided in the

Administrative Procedures Act for a given class of cases, without intending to foreclose a beneficiary from obtaining *any* judicial remedy for a refusal by a carrier to pay what is statutorily and constitutionally required.

The few sentences of legislative history cited by the Government are ambiguous and far too uncertain a basis on which to ground the Government's drastic conclusion. In the absence of clear Congressional intent to the contrary, the Court of Claims was not barred from exercising its jurisdiction under 28 U.S.C. § 1491. *See Johnson* v. *Robison*, 415 U.S. 361, 373 (1974); *Abbott Laboratories* v. *Gardner*, 387 U.S. 136, 140 (1967).

B. *42 U.S.C. § 405(h) Does Not Preclude Court of Claims Jurisdiction Over Part B Benefit Determinations*

1. *The United States' Position Unnecessarily Raises Serious Constitutional Questions.*

The United States also argues that § 205(h) of the Social Security Act, 42 U.S.C. § 405(h) (1976), precludes all judicial review of Part B benefit determinations. Its reasoning raises serious constitutional questions.

Section 405(h) provides:

> The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, of any officer or employee thereof shall be brought under sections 1331 and 1346 of title 28 to recover on any claim arising under this subchapter.[8]

That section is adopted by reference for the Medicare program, with conditions, in 42 U.S.C. § 1395ii (1976):

[8] The 1976 edition of the United States Code, quoted above, has not been enacted into positive law. In the 1970 edition, "sections 1331 and 1346" of title 28 are referred to as "section 41" of title 28, the designation contained in the Social Security Act. For clarity the current designation is used herein.

> "the provisions of . . . subsection . . . (h) . . . of section 405 of this title, shall also apply with respect to this subchapter to the same extent as [it is] applicable with respect to subchapter II of this chapter."

As originally enacted in the Social Security Act, § 405(h) was tied closely to § 405(g). The latter section provides a particular mechanism for judicial review in the district courts of final decisions by the Secretary. Thus, the preclusion of judicial review in the second sentence of § 405(h) was substantially softened by the exception to that preclusion, "except as herein provided", because § 405(g) did provide a judicial review mechanism.

In *Weinberger* v. *Salfi*, 422 U.S. 749 (1975), this Court considered the effect of the preclusionary language of § 405(h) on district court jurisdiction. In that case the plaintiffs had attacked the constitutionality of certain sections of the Social Security Act. Jurisdiction in the district court over that constitutional claim was asserted by the plaintiffs under 28 U.S.C. § 1331.

This Court held that the third sentence of § 405(h) did in fact deprive the district court of jurisdiction under 28 U.S.C. § 1331 even to consider constitutional attacks on the Social Security Act. That third sentence reads: "No action against the United States, the Secretary, or any officer or employee thereof shall be brought under sections 1331 and 1346 of title 28 to recover on any claim arising under this subchapter."

Central to the *Salfi* opinion is this Court's recognition that it was *not* foreclosing constitutional claims from all judicial forums: it held that § 405(g) provided such a forum, in the district court statutory review procedures. Therefore, this Court did not have to deal with the serious problem which a preclusion of constitutional claims from all judicial scrutiny would have raised. It stated that such a restriction on the availability of judicial review "[n]ot only would . . . have been extraordinary, such that 'clear and convincing' evidence would be required before we would ascribe such intent to

Congress, . . . but it would have raised a serious constitutional question of the validity of the statute as so construed." 422 U.S. at 762 (citations omitted). The *Salfi* decision was reaffirmed in *Mathews* v. *Eldridge*, 424 U.S. 319 (1976).

In the Medicare Act, however, § 405(h) was adopted by reference *without* the accompanying statutory review provisions of § 405(g). 42 U.S.C. § 1395ii (1976). The saving judicial review provision of § 405(g) thus is not available to avoid the constitutional dilemma which § 405(h) otherwise would have caused in *Salfi*.

Since *Salfi*, the United States has repeatedly precipitated that serious constitutional dilemma by apparently seeking to have all judicial forums for review of Medicare Part B benefit determinations and certain Part A statutory and constitutional claims closed. For example, in *United States* v. *Aquavella*, 615 F.2d 12 (2nd Cir. 1979), the United States unsuccessfully contended that because of § 405(h), a determination made by a Part A fiscal intermediary and affirmed by HEW that funds were owed to HEW by a provider could not be reviewed in any forum, even by the district court with jurisdiction over the United States' claim to recover those funds. In the instant case, the United States' contentions are equally broad:

> . . .[N]o "tribunal"—in this case, the Court of Claims—may review the carriers' findings of fact or decision except as otherwise provided in the Medicare Act itself. Since nothing in the Medicare Act provides for judicial review in these circumstances, review is barred by the literal terms of the second sentence of 42 U.S.C. § 405(h). . . .

U.S. Br. at 34.

> ". . .Indeed, by the cumulation of prohibitions in 42 U.S.C. § 405(h), Congress clearly has manifested its intent to foreclose all review of administrative findings and conclusions in this context. . . .

U.S. Br. at 35 n.32.

Chief Justice Marshall's discussion in *Marbury* v. *Madison*, 5 U.S. (1 Cranch.) 135 (1803) underscores the inherent infirmity of the United States' position here:

> "...[W]here a specific duty is assigned by law, and individual rights depend upon the performance of that duty, it seems equally clear that the individual who considers himself injured, has a right to resort to the laws of his country for a remedy."

5 U.S. at 165, 1 Cranch. at 166.

> "The government of the United States has been emphatically termed a government of laws, and not of men. It will certainly cease to deserve this high appellation, if the laws furnish no remedy for the violation of a vested legal right.

5 U.S. at 162, 1 Cranch. at 163.

> "The question whether a right has vested or not, is, in its nature, judicial, and must be tried by the judicial authority...."

5 U.S. at 165, 1 Cranch. at 167.

The United States argues for an interpretation of a federal law, silent as to judicial review of the decisions of a private carrier, which would preclude all judicial scrutiny of contractual, statutory and constitutional violations by the carrier. It claims, moreover, that the federal government can by contract delegate governmental functions to a private party and yet preclude a person injured by the blatantly illegal acts of that party, in violation of its contract, from obtaining any judicial relief from those illegal acts. Even if the Medicare statute and the Tucker Act were ambiguous, they should be interpreted so as to avoid such a result. *Johnson* v. *Robison*, 415 U.S. 361 (1974).

The United States seeks to avoid this serious constitutional issue by arguing that this Court should reverse the decision below without facing the issue of whether the Court of Claims

has jurisdiction to decide constitutional claims under Part B. That assertion is erroneous. With respect to Medicare benefit decisions, this Court has stated that pursuant to 42 U.S.C. § 405(h), there is no jurisdiction in the district courts under 28 U.S.C. § 1331 to review constitutional challenges to the Social Security Act. *Weinberger* v. *Salfi*, 422 U.S. 749 (1975). With respect to Part B Medicare carrier decisions, no § 405(g) review proceedings are provided. Section 405(h) thus applies to preclude § 1331 jurisdiction over such constitutional claims in the district courts and no other district court jurisdiction is granted.[9] The United States asserts that the Court of Claims is precluded from reviewing carrier decisions by the same statutory language and hence to the same extent as the district courts. Of necessity it is therefore asserting that no judicial forum has jurisdiction over colorable claims that a carrier has violated the Constitution.

This case need not require this Court to determine whether Congress can circumvent the Constitution by delegating the powers of the United States to private parties and than allow-

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[9] It has been suggested that the district courts might have mandamus jurisdiction over Part B claims under 28 U.S.C. § 1361 (1976). See *Mathews* v. *Eldridge*, 424 U.S. 319, 332 n.12 (1976). That statute, however, only gives district courts jurisdiction "to compel an officer or employee of the United States or any agency thereof to perform a duty owed to the plaintiff." It is doubtful whether Prudential is an "officer or employee" of the United States or any agency. Whether the Secretary could be compelled in a mandamus action to enforce his contract with Prudential, and thus indirectly to allow Erika the relief to which it is entitled, is equally doubtful. Nothing express in the Medicare statute requires the Secretary to take action to enforce every term of every contract into which he has entered. Mandamus ordinarily lies only to enforce a nondiscriminatory, ministerial duty to act that is so plainly prescribed by law as to be free from doubt. *See Wilbur* v. *United States*, 281 U.S. 206, 218-19 (1930); *Cervoni* v. *Secretary of HEW*, 581 F.2d 1010, 1019 (1st Cir. 1978) ("The mandamus remedy is only available under exceptional circumstances of clear illegality.") In any event, the United States' claim that 42 U.S.C. § 405(h) prohibits all judicial scrutiny of part B decisions would, if upheld, apply to District Court "nonstatutory" review to the same extent that it would apply to Court of Claims review.

ing the private parties to violate the statute, the Constitution and their contracts without judicial constraint. If the United States' interpretation of the statute were upheld, that serious, indeed monumental constitutional issue would have to be addressed.

In *McClure* v. *Harris*, 503 F.Supp. 409 (N.D. Cal. 1980), the district court was faced with a related constitutional dilemma. The plaintiff in *McClure* had challenged, under the due process clause, the constitutional adequacy of Part B hearing procedures. In particular the challenge focused on the fact that Part B hearing officers are tied to the carriers by the power of appointment and often as well by employment and other pecuniary interests, that they are given little or no formal training and are not required to meet any threshold qualifications for employment. The district court apparently assumed that there was no judicial or administrative review available from an adverse carrier hearing. "...[I]f no independent tribunal is ever to review a hearing officer's decision, then impartiality must be fully ensured at the hearing-officer level." *Id.* at 414. It therefore concluded that the Part B procedures were not impartial or constitutionally adequate and declared the entire system of carrier "fair hearings" to be unconstitutional. Had the district court been aware of a right to judicial review, its decision might well have been different.

The United States has sought to appeal *McClure* v. *Harris* to this Court. *See* U.S. Br. at 23 n.20. The constitutional issue in *McClure* v. *Harris*, in Erika's view, may be at least partially avoided by recognizing the right to overturn carrier statutory and constitutional violations through a suit for damages in the Court of Claims.

2. *42 U.S.C. § 405(h) Should Be Read Not To Preclude Court of Claims Jurisdiction.*

Faced with this Court's ruling in *Salfi*, and the United States' insistence that all channels of judicial relief for Part B benefit claims and certain Part A claims have been closed,

the Courts of Appeals, the Court of Claims and numerous district courts have acknowledged the constitutional dilemma posed by the United States' position, and have consistently interpreted § 405(h) to avoid that dilemma. Despite differing specific interpretations, a common thread runs through these decisions: § 405(h) need not and should not be interpreted to indicate a congressional intent to eliminate all "nonstatutory" district court and Court of Claims review.

For example, in *St. Louis Univ.* v. *Blue Cross Hosp. Serv.*, 537 F.2d 283 (8th Cir.), *cert. denied*, 429 U.S. 977 (1976), the Eighth Circuit purported to follow *Salfi* in a Medicare case involving both Part A and Part B issues. It held that while § 405(h) deprived the district court of § 1331 jurisdiction over a claim for Medicare payments, it did not deprive it of jurisdiction under § 1331 to require a constitutionally adequate hearing as to Medicare benefits. The Eighth Circuit rested its decision in substantial part on the perception that no judicial review of the due process claim would otherwise be available under the Medicare Act, 537 F.2d at 293.

In *Trinity Memorial Hosp. of Cudahy, Inc.* v. *Associates Hosp. Serv., Inc.*, 570 F.2d 660 (7th Cir. 1977), the plaintiff claimed that under Part A it was entitled to an additional payment of reimbursable costs both on statutory and constitutional grounds. Such a claim fell outside the scope of the § 405(g) review procedures, and the United States argued that § 405(h) therefore precluded all judicial review. 507 F.2d at 666. The Seventh Circuit agreed that § 405(h) deprived the district courts of § 1331 jurisdiction, specifically disagreeing with the Eighth Circuit holding in the *St. Louis University* case, *supra*. It stated, however, that "[t]here can be little doubt that the Court of Claims has jurisdiction . . ." over a due process Part A reimbursement claim, 570 F.2d at 667, thus avoiding the constitutional issue.

The Fifth Circuit, in *Dr. John T. MacDonald Foundation, Inc.* v. *Califano*, 571 F.2d 328 (5th Cir.), *cert. denied*, 439

U.S. 893 (1978), agreed with the Seventh Circuit. It held that § 405(h) precludes district court review of constitutional claims under the Medicare Act, but it did so only in light of its view that Court of Claims jurisdiction was not barred by § 405(h). 571 F.2d at 332. *Accord, South Windsor Convalescent Home, Inc.* v. *Mathews*, 541 F.2d 910 (2nd Cir. 1976).

In *Chelsea Community Hosp.* v. *Michigan Blue Cross Ass'n*, 630 F.2d 1131 (6th Cir. 1980), the Sixth Circuit addressed both *Salfi* and § 405(h) directly. It stated that *Salfi*, and the restrictions in § 405(h), made sense only in context, that is, only under the Social Security Act which provided alternative review in § 405(g). It reasoned that in the Medicare context, incorporation of § 405(h) by reference "as applicable," 42 U.S.C. § 1395ii (1976), did not show "clear and convincing" Congressional intent to preclude review. Rather, § 405(h) "does not have a meaningful application in a case where no statutory review mechanism is available, for the purpose of § 405(h), following *Salfi*, is 'simply the enforcement of the [42 U.S.C.] Section 405(g) procedures and prerequisites to judicial review.' " 630 F.2d at 1135, citation omitted.

The Second Circuit, in *United States* v. *Aquavella*, 615 F.2d 12 (2nd Cir. 1979), was squarely presented with the constitutional dilemma, since in that case there was no basis for Court of Claims' jurisdiction. (The United States was seeking a money judgment against Aquavella.) It held that the first sentence of § 405(h) by its terms does not apply to findings and decisions not made by the Secretary; that the second sentence is irrelevant when no alternative method of review is provided under the Medicare Act; and that the third sentence by its terms only applies to claims against the United States under 28 U.S.C. §§ 1331 or 1346. 615 F.2d at 19. It therefore found no congressional intent to deprive claimants of a right to sue in the Court of Claims or to preclude other forms of "nonstatutory" judicial review. *Id.* at 20.

The Court of Claims has consistently agreed with the opinions of the Circuit Courts of Appeals that Congress did not intend

to foreclose all Medicare claims from judicial review. In *Whitecliff, Inc.* v. *United States*, 210 Ct. Cl. 53, 536 F.2d 347 (1976), *cert. denied*, 430 U.S. 969 (1977), that Court held that § 405(h) did not prevent a provider under Part A from bringing an action for a money judgment in the Court of Claims when the statutory provisions for review in the district court were unavailable. In *Whitecliff*, as in the instant case, the administrative decision resulting in the claim was made by a private party (a "fiscal intermediary" under Part A) with the only administrative review available a hearing before a private appellate board. The Court of Claims, in rejecting the government's contention, was particularly influenced by the fact that to accept the government's contention "would be to prevent all review of very large categories of cases and issues, including constitutional questions, and to accord absolute finality to adjudications by private organizations . . ." 210 Ct. Cl. at 58, 536 F.2d at 350.

The Court of Claims' decision, like the decisions of the Circuit Courts of Appeals, is consistent with the language of the statute. The Government asserts that a decision by a carrier after a hearing conducted by the carrier is included within the language of the first sentence of § 405(h): "findings and decisions of the Secretary after a hearing . . . ." Giving the statutory language its plain meaning, however, Prudential is not the Secretary of Health and Human Services,[10] and the first sentence of § 405(h) simply does not apply.

The second sentence likewise refers to findings and decisions "of the Secretary." That language does not apply to a decision of a private carrier. Moreover, § 1395ff distinguishes between determinations to be made by the Secretary and determina-

[10] Congress manifested its intent to have different decisionmakers address different classes of decisions, even though ultimately the United States is the real party in interest in defending the decisions of both. *See* discussion *supra* at 13. The fact that the United States is the real party in interest in defending the decisions of both decisionmakers does not compel the conclusion that Congress considered the decisionmakers to be one and the same.

tions to be made by others, and specifically allows judicial review under § 405(g) only as to those decisions required to be made *by the Secretary*. Section 405(h), read together with § 405(g), simply does not relate to carrier decisions.

Section 1395u, which sets forth the procedures to be followed by carriers, in no way equates a decision by a carrier with a decision by the Secretary. It is unlikely that Congress would clearly distinguish in §§ 1395ff & 1395u between proceedings to be conducted by the Secretary and proceedings to be conducted by a carrier, while in another section intending that a reference to a decision by the "Secretary" be construed as a decision by the carrier.

In addition, the specific preclusion by the third sentence of § 405(h) of actions in the district courts under section 41 of title 28 (28 U.S.C. §§ 1331 & 1346) to recover on a claim for benefits under Part B of Medicare lends support to the continued exercise of Court of Claims jurisdiction as the appropriate forum for such cases. If Congress had wanted to preclude Court of Claims' jurisdiction, it knew how to do so explicitly. It specifically and deliberately precluded certain district court jurisdiction. Its silence as to the Court of Claims indicates that it did not intend to preclude Court of Claims jurisdiction.

The United States has asserted that "[i]t is most unlikely that Congress would have intended to permit an individual beneficiary or his assignee to *sue the United States* to recover on a claim that has been denied by a carrier, when Congress has not provided any prior opportunity for administrative review by expert agency officials in HHS . . . ." U.S. Br. at 26 (Emphasis in original). It is even more unlikely that Congress would intentionally permit a private party to make decisions involving many millions of public dollars, affecting medical insurance benefits of crucial importance to millions of Americans, and yet allow those decisions to be absolutely final, binding on the government and on private parties, subject to no scrutiny whatsoever by any government officer, agency, public body or court.

IV. The Decision Neither Opens the Floodgates to New Litigation Nor Changes Existing Law in Any Significant Way

The Government has implied that the decision below would open the floodgates to litigation:

> "... [m]ore than 150 million reimbursement claims are now filed under Part B each year. Statistics compiled by the Department of Health and Human Services disclose that during calendar year 1980, Part B carriers such as Prudential received 2,163,786 requests for informal review of their initial determinations. See 42 C.F.R. 405.807 *et seq.*; note 18, *supra*. The carriers affirmed their initial determinations in 975,143 of these cases. During the same period, carriers received 26,171 requests for "fair hearings," and their determinations were upheld after a hearing in 7191 cases. If only a fraction of the total number of disappointed claimants were to seek review in the Court of Claims or the district courts, the cited statistics demonstrate that there would be a significant increase in the workload of these courts. This would, in turn, strain the scarce resources of the Secretary and the Attorney General in defending against relatively minor monetary claims ...

U.S. Br. at 32-33

That contention is unrealistic. As an initial matter, the expense of litigating in the Court of Claims would of its own force screen out all but the most substantial disputes. The Government cannot seriously contend that the Court of Claims' docket is likely to become cluttered with $50 (or even $500) cases.[11] In any event the Court of Claims, which should be most familiar with its own docket, did not share the Government's opinion that that Court might become over-

[11] The instant case involves hundreds of thousands of dollars, by Erika's calculations.

burdened or even that the resources of the Secretary would be overtaxed by a sudden influx of cases into the Court of Claims. *Erika, Inc.* v. *United States, supra*, 634 F.2d at 588 (Pet. App. 14a-15a).

Furthermore, the instant decision of the Court of Claims did not change its prior view of its jurisdiction. The Court of Claims merely followed a long line of precedent, including *Goldstein* v. *United States, supra; Appalachian Regional Hosp., Inc* v. *United States, supra; Whitecliff, Inc.* v. *United States, supra. See Overlook Nursing Home, Inc.* v. *United States, supra.* The "floodgates" have in fact been open for years, but the resultant "flood" of litigation appears to have consisted primarily of Erika's suit.

Indeed, the fact that the Court of Claims has jurisdiction over Part B issues has been so widely assumed and relied on that even the cases cited by the United States as denying federal district court jurisdiction over Part B claims often state that even if the district courts lack such jurisdiction, the Court of Claims is one forum which has it. For example, the United States cites *Bussey* v. *Harris*, 611 F.2d 1001 (5th Cir. 1980), to support the proposition that several decisions of Courts of Appeals hold that there is no right of judicial review *in the district courts* of a carrier's benefit determinations under Part B. (U.S. Br. at 31). The *Bussey* v. *Harris* court also stated, as one of the factors in support of its decision:

> Review is available in the Court of Claims if litigants can state a claim for actual or nominal damages .... This holds true for Part B as well as for Part A actions ....
>
> Appellants could have sought damages in their complaint, although they instead requested declaratory and injunctive relief. Judicial review of any substantial constitutional or statutory claim, therefore, is available in the Court of Claims under 28 U.S.C. § 1491.

611 F.2d 1005 n.6. *Accord, Drennan* v. *Harris*, 606 F.2d 846, 850 (9th Cir. 1979) (also cited by the United States for the same proposition, U.S. Br. at 31); *Pushkin* v. *Califano*, 600 F.2d

486, 489-90 (5th Cir. 1979). *See Fox* v. *Harris*, 488 F.Supp. 488, 495 (D.D.C. 1980); *United States* v. *Bellevue Hosp. Inc.*, 479 F.Supp. 780, 784 (D. Mass. 1979). The Court of Claims did not announce anything in this case which has not been known and accepted by other courts, litigants and potential litigants for years.

Moreover, the Court of Claims' actions in this case were consistent with a severely limited view of its jurisdiction. The court found specific violations of the Medicare statute but refused to take the step of conducting a review of the "thousands" of individual benefit determinations the United States claims were at issue. Those it remanded to Prudential to determine consistent not only with the statute but also with the carrier's discretion:

> On the present record, we cannot determine what Erika's customary charges were for its drugs and services for each of the calendar years involved. Nor do we attempt to prescribe the method by which the carrier should make that determination. Prudential might decide to average the different charges made during the calendar year, or to allocate the different charges on the basis of the time each was in effect, or to determine the mean charge, or to use some combination of these methods. Perhaps Prudential can devise a better method of calculation.
>
> The selection of the appropriate method of calculation is for Prudential to determine in the first instance. The carrier has considerable discretion to adopt whatever method of calculation it concludes would most accurately measure and reflect Erika's customary charges during the preceding calendar year.

Erika, Inc. v. *United States, supra*, 634 F.2d at 589 (Pet. App. 17a).

> The regulations give carriers substantial flexibility in setting reimbursement rates to look at more than just the customary and prevailing charges .... The determination whether to grant particular adjustments and permit departures from prevailing charges during the preceding calendar year, however, is within the discretion of the carrier. We cannot direct Prudential whether or how to exercise that discretion in a particular case.

634 F.2d at 591 (Pet. App. 21a).

The Court of Claims has neither opened the floodgates of litigation nor acted in a manner which would encourage attempts to define away the carefully delineated limits on its jurisdiction.

Finally, mere recitation of possible administrative convenience as a reason for denying jurisdiction hardly establishes the requisite clear and convincing evidence of congressional intent to preclude review.

> ... [T]he agency harnesses that old workhorse, administrative convenience: we are told that given the complexity of provider reimbursements, "Congress reasonably assumed that to permit judicial review of the Secretary's determinations would unduly burden the already considerable administrative task." Judicial review is always inconvenient for administrators, as it is for everyone else involved. If administrative convenience were enough to destroy the presumption favoring judicial review of administrative action, that presumption would be a sham. Conjuring administrative inconvenience cannot "clearly and convincingly" show a legislative intent to preclude review.

Chelsea Community Hosp. v. *Michigan Blue Cross Ass'n*, *supra*, 630 F.2d at 1136.

Because a reasonable and principled alternative exists to deciding the constitutional questions of withdrawal of all avenues of judicial review, of improper delegation of judicial and executive authority to private parties and of the inadequacy of carrier-conducted administrative "review," that alternative should be chosen. *Johnson* v. *Robison, supra*. The jurisdiction of the Court of Claims should continue to be recognized, as limited by the court below, to include claims for money damages for statutory or constitutional violations in denying statutorily mandated payments to Part B Medicare beneficiaries and providers.

Conclusion

The decision of the Court of Claims should be affirmed.

Respectfully submitted,

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APPENDIX

42 U.S.C. §405:

(h) The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 41 of Title 28 to recover on any claim arising under this subchapter.*

42 U.S.C. §1395u:

(a) In order to provide for the administration of the benefits under this part with maximum efficiency and convenience for individuals entitled to benefits under this part and for providers of services and other persons furnishing services to such individuals, and with a view to furthering coordination of the administration of the benefits under part A and under this part, the Secretary is authorized to enter into contracts with carriers, including carriers with which agreements under section 1395h of this title are in effect, which will perform some or all of the following functions (or, to the extent provided in such contracts, will secure performance thereof by other organizations); and, with respect to any of the following functions which involve payments for physicians' services on a reasonable charge basis, the Secretary shall to the extent possible enter into such contracts:

(1)(A) make determination of the rates and amounts of payments required pursuant to this part to be made to providers of services and other persons on a reasonable cost or reasonable charge basis (as may be applicable):

(B) receive, disburse, and account for funds in making such payments; and

(C) make such audits of the records of providers of services as may be necessary to assure that proper payments are made under this part;

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* In the 1976 edition of the United States Code, which has not been enacted into positive law, the reference to "section 41" is changed to refer to the present "sections 1331 and 1346" of Title 28.

(2)(A) determine compliance with the requirements of section 1395x(k) of this title as to utilization review; and

(B) assist providers of services and other persons who furnish services for which payment may be made under this part in the development of procedures relating to utilization practices, make studies of the effectiveness of such procedures and methods for their improvement, assist in the application of safeguards against unnecessary utilization of services furnished by providers of services and other persons to individuals entitled to benefits under this part, and provide procedures for and assist in arranging, where necessary, the establishment of groups outside hospitals (meeting the requirements of section 1395x(k)(2) of this title) to make reviews of utilization;

(3) serve as a channel of communication of information relating to the administration of this part; and

(4) otherwise assist, in such manner as the contract may provide, in discharging administrative duties necessary to carry out the purposes of this part.

(b)(1) Contract with carriers under subsection (a) of this section may be entered into without regard to section 5 of Title 41 or any other provision of law requiring competitive bidding.

(2) No such contract shall be entered into with any carrier unless the Secretary finds that such carrier will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, and other matters as he finds pertinent.

(3) Each such contract shall provide that the carrier—

(A) will take such action as may be necessary to assure that, where payment under this part for a service is on a cost basis, the cost is reasonable cost (as determined under section 1395x(v) of this title);

(B) will take such action as may be necessary to assure that, where payment under this part for a service is on a charge basis, such charge will be reasonable and not higher than the charge applicable, for a comparable service and under comparable circumstances, to the policy holders and subscribers of the carrier, and such payment will (except as otherwise provided in section 1395gg(f) of this title) be made—

(i) on the basis of an itemized bill; or

(ii) on the basis of an assignment under the terms of which (I) the reasonable charge is the full charge for the service (II) the physician or other person furnishng such service agrees not to charge for such service if payment may not be made therefor by reason of the provisions of paragraph (1) of section 1395y of this title, and if the individual to whom such service was furnished was without fault in incurring the expense of such service, and if the Secretary's determination that payment (pursuant to such assignment) was incorrect and was made subsequent to the third year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this subchapter (except in the case of physician's services and ambulance service furnished as described in section 1395y(a)(4) of this title, other than for purposes of section 1395gg(f) of this title);

but (in the case of bills submitted, or requests for payment made, after March 1968) only if the bill is submitted, or a written request for payment is made in such other form as may be permitted under regulations, no later than the close of the calendar year following the year in which such service is furnished (deeming any service furnished in the last 3 months of any calendar year to heve been furnished in the succeeding calendar year);

(C) will establish and maintain procedures pursuant to which an individual enrolled under this part will be granted an opportunity for a fair hearing by the carrier, in any case where the amount in controversy is $100 or more, when requests for payment under this part with respect to services furnished him are denied or are not acted upon with reasonable promptness or when the amount of such payment is in controversy;

(D) will furnish to the Secretary such timely information and reports as he may find necessary in performing his functions under this part; and

(E) will maintain such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of the information and reports under subparagraph (D) and otherwise to carry out the purposes of this part;

and shall contain such other terms and conditions not inconsistent with this section as the Secretary may find necessary or appropriate. In determining the reasonable charge for services for purposes of this paragraph, there shall be taken into consideration the customary charges for similar services generally made by the physician or other person furnishing such services, as well as the prevailing charges in the locality for similar services. No charge may be determined to be reasonable in the case of bills submitted or requests for payment made under this part after December 31, 1970, if it exceeds the higher of (i) the prevailing charge recognized by the carrier and found acceptable by the Secretary for similar services in the same locality in administering this part on December 31, 1970, or (ii) the prevailing charge level that, on the basis of statistical data and methodology acceptable to the Secretary, would cover 75 percent of the customary charges made for similar services in the same locality during the last preceding calendar year elapsing prior to the start of the fiscal year in which the bill is submitted or the request for payment is made.

In the case of physician services the prevailing charge level determined for purposes of clause (ii) of the preceding sentence for any fiscal year beginning after June 30, 1973, may not exceed (in the aggregate) the level determined under such clause for the fiscal year ending June 30, 1973, except to the extent that the Secretary finds, on the basis of appropriate economic index data, that such higher level is justified by economic changes. In the case of medical services, supplies, and equipment (including equipment servicing) that, in the judgment of the Secretary, do not generally vary significantly in quality from one supplier to another, the charges incurred after December 31, 1972, determined to be reasonable may not exceed the lowest charge levels at which such services, supplies, and equipment are widely and consistently available in a locality except to the extent and under the circumstances specified by the Secretary. The requirements in sub-paragraph (B) that a bill be submitted or request for payment be made by the close of the following calendar year shall not apply if (i) failure to submit the bill or request the payment by the close of such year is due to the error or misrepresentation of an officer, employee, fiscal intermediary, carrier, or agent of the Department of Health, Education, and Welfare performing functions under this subchapter and acting within the scope of his or its authority, and (ii) the bill is submitted or the payment is requested promptly after such error or misrepresentation is eliminated or corrected.

(4) Each contract under this section shall be for a term of at least one year, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term; except that the Secretary may terminate any such contract at any time (after such reasonable notice and opportunity for hearing to the carrier involved as he may provide in regulations) if he finds that the carrier has failed substantially to carry out the contract or is carrying out the contract in a manner inconsis-

tent with the efficient and effective administration of the insurance program established by this part.

(5) No payment under this part for a service provided to any individual shall (except as provided in section 1395gg of this title) be made to anyone other than such individual or (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) the physician or other person who provided the service, except that payment be made (A) to the employer of such physician or other person if such physician or other person is required as a condition of his employment to turn over his fee for such service to his employer, or (B) (where the service was provided in a hospital, clinic, or other facility) to the facility in which the service was provided if there is a contractual arrangement between such physician or other person and such facility under which such facility submits the bill for such service.

(c) Any contract entered into with a carrier under this section shall provide for advances of funds to the carrier for the making of payments by it under this part, and shall provide for payment of the cost of administration of the carrier, as determined by the Secretary to be necessary and proper for carrying out the functions covered by the contract.

(d) Any contract with a carrier under this section may require such carrier or any of its officers or employees certifying payments or disbursing funds pursuant to the contract, or otherwise participating in carrying out the contract, to give surety bond to the United States in such amount as the Secretary may deem appropriate.

(e)(1) No individual designated pursuant to a contract under this section as a certifying officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payments certified by him under this section.

(2) No disbursing officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payment by him under this section if it was

based upon a voucher signed by a certifing officer designated as provided in paragraph (1) of this subsection.

(3) No such carrier shall be liable to the United States for any payments referred to in paragraph (1) or (2).

(f) For purposes of this part, the term "carrier" means—

(1) with respect to providers of services and other persons, a voluntary association, corporation, partnership, or other non-governmental organization which is lawfully engaged in providing, paying for, or reimbursing the cost of, health services under group insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier, including a health benefits plan duly sponsored or underwritten by an employee organization; and

(2) with respect to providers of services only, any agency or organization (not described in Paragraph (1)) with which an agreement is in effect under section 1395h of this title.

(g) The Railroad Retirement Board shall, in accordance with such regulations as the Secretary may prescribe, contract with a carrier or carriers to perform the functions set out in this section with respect to individuals entitled to benefits as qualified railroad retirement beneficiaries pursuant to section 426(a) of this title and section 228s-2(b) of title 45.

42 U.S.C. §1395ff:

(a) The determination of whether an individual is entitled to benefits under part A or part B of this subchapter, and the determination of the amount of benefits under part A of this subchapter, shall be made by the Secretary in accordance with regulations prescribed by him.

(b)(1) Any individual dissatisfied with any determination under subsection (a) of this section as to—

(A) whether he meets the conditions of section 426 or 426a of this title, or

(B) whether he is eligible to enroll and has enrolled pursuant to the provisions of part B of this subchapter, or section 1395i-2 of this title or section 1819, or

(C) the amount of benefits under part A of this subchapter (including a determination where such amount is determined to be zero)

shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 405(b) of this title and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.

(2) Notwithstanding the provisions of subparagraph (C) of paragraph (1) of this subsection, a hearing shall not be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $100; nor shall judicial review be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $1,000.

(c) Any institution or agency dissatisfied with any determination by the Secretary that it is not a provider of services, or with any determination described in section 1395cc(b)(2) of this title, shall be entitled to a hearing thereon by the Secretary (after reasonable notice and opportunity for hearing) to the same extent as is provided in section 405(b) of this title, and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.